Date_____ Home Phone_____
Referred By _____ Cell Phone _____
Email _____ Work Phone_____

Patient Name_____
Last First

Preferred Name_____
Address_____
City_____ State_____ Zip_____
Social Security #_____
Sex M F Birthdate__/__/____ Status: Single Married Widowed Divorced
Employed by_____ Occupation_____

MEDICAL HISTORY

Physicians Name_____ Date of Last Physical_____
Have you ever had any of the following? (check which apply)

__AIDS/HIV	__Glaucoma	__Nervous Problems	__Other
__Arthritis	__Headaches	__Pacemaker	
__Artificial Heart Valves	__Heart Murmur	__Psychiatric Care	
__Artificial Joints	__Heart Problems	__Radiation Treatment	
__Asthma	__Hepatitis	__Respiratory Disease	
__Back Problems	__Herpes	__Rheumatic Fever	
__Cancer	__High Blood Pressure	__Sinus Trouble	
__Chemical Dependency	__Jaw Pain	__Skin Rash	
__Chemotherapy	__Kidney Disease	__Stroke	
__Circulatory Problems	__Liver Disease	__Thyroid Problems	
__Diabetes	__Low Blood Pressure	__Tuberculosis	
__Epilepsy/Seizures	__Mitral Valve Prolapse	__Ulcers	

Allergy/reaction to: Anesthetics Asprin Codeine Iodine Latex Penicillin Sulfa Other _____

What medications do you currently take? _____
_____
_____

Are you happy with your smile? Yes No
If you had a magic wand, what (if anything) would you change about your smile? _____
_____

Are you anxious about dental treatment? Yes No **Would you like to be sedated?** Yes No
What can we do to make your visits more pleasant for you?_____
_____
_____

Do you use tobacco products? Yes No

Women: **Are you pregnant?** Yes No **Nursing?** Yes No **Taking Birth Control Pills?** Yes No